STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT
STATE OF NEW MEXICO

Attachment 4.19-B

Methods and Standards of Establishing Payment Rates - Other Types of Care

I. Payment to providers on a fee for service basis is limited to the lesser of the actual charge or the fee schedule established by the Department.

Providers reimbursed on a fee for service basis include physicians, dentists, radiologists and radiological laboratories, pathologists and clinical pathology laboratories, free-standing clinics (other than rural health clinics or federally qualified health centers), podiatrists, psychologists, optometrists, audiologists, and therapy providers (including occupational therapy, physical therapy, speech-language-hearing therapy, and other rehabilitative therapies).

a. The fee schedule was established using the following:

1. Relative Value Scales

Relative Values for Physicians, 2nd Edition, 1986 was used to assign unit values to physician procedures. The unit values established an appropriate relativity between the procedures and was used as initial base upon which to begin constructing the fee schedule. For dental services, association reports on dental fees JADA, Vol. 113, November, 1986, was used to assign a relative value scale. For other services, billed charge history of the Medical Assistance Program for the calendar year 1986 was used to develop relative value units.

2. Groups for Calculation of Reimbursement

Frequently billed procedures were identified and divided into groups according to CPT body system, type of physician visit, type of provider, or type of service. The groupings were used to established appropriate reimbursement for a procedure relative to other procedures in the same group.

3. Billed Charges

Average billed charges to the New Mexico Medical Assistance Program were calculated for each procedure for the calendar year 1986. For frequently performed procedures, significant deviation between the average billed amount for a procedure and the assigned unit value resulted in a re-examination of the unit value. When appropriate, the unit value was changed to accurately reflect billed charge history. A conversion factor was calculated for each of the frequently billed procedures by dividing the unit value into the average billed amount. An average conversion factor was then calculated for each group.

4. History of Paid Claims

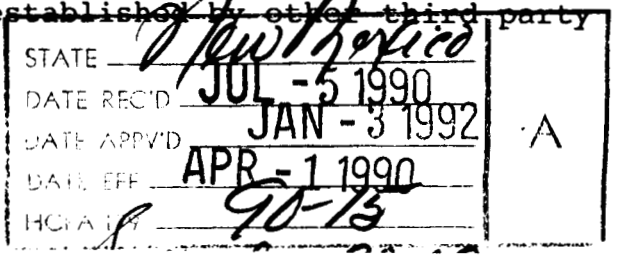
The average amount of payment for each procedure was calculated for the calendar year 1986. As the fee schedule was not intended as fee increase, the average conversion factor was reduced by the percentage paid of billed charges for 1986 for the procedures in each group.

5. Weighted Conversion Factors

A final conversion factor weighted by frequency was calculated for each group of procedures. The weighted conversion factor for each group of procedures was reduced by the necessary percentage to assure expenditures would be within budgeted amounts. The final weighted conversion factor for each group was multiplied by the unit value of each procedure to calculate the maximum reimbursement for each procedure.

6. Establishing a Fee Schedule

A final review establishing the fee schedule was conducted by the Medical Assistance Division. Services are added to the fee schedule as needed (such as for new or infrequently billed procedures) using the same methodology. For services without a billing history, the Department establishes the maximum allowed reimbursement at rates comparable to procedures on the fee schedule having similar complexity, having similar risk factors, and requiring a similar amount of time, and with consideration of the payment levels ~~established by other third party~~ payers.



7. Adjustments to Fee Schedule

When appropriations are made to adjust payment for physician services by the legislature, the appropriation will be applied to low paid procedures and to services for which access problems exist, or as otherwise directed by the appropriation following a public hearing on such adjustments.

Pursuant to State legislative appropriations, physician fees are increased effective March 1, 1996, for office-based Evaluation and Management Services, prenatal and obstetrical delivery services, and the medical screen of the Tot to Teen HealthCheck. Increased fees are based on the 1994 Medicare Participating Provider Fee Schedule. Routine global prenatal care and Cesarean delivery currently exceed the Medicare 1994 fee schedule, therefore the fees for these two services are increased 10 percent. The Tot to Teen HealthCheck is increased to $45.00.

b. A group practice is reimbursed at the rate payable to the individual performing physician or provider. For a service for which a performing physician or provider is not identified, reimbursement will be made at the rate payable to the group.

c. Reimbursement for physician services furnished in hospital outpatient settings that are also ordinarily furnished in a physician's office is determined by using the Department's fee schedule for each professional service and multiplying the allowed amount by .60.

This reimbursement methodology is applicable only to physician's professional services in hospital outpatient settings (i.e., a hospital clinic, hospital office, the outpatient department). Excluded from this reimbursement methodology are services provided in rural health clinics, surgical services in an ambulatory setting, emergency services, anesthesiology services, diagnostic and therapeutic radiology services, and services provided by physicians who are compensated by or through the hospital and whose services are reimbursed on a compensation related charge basis. Services billed by physicians in teaching hospital whose Medicare Part B reimbursement is not based on a compensation related basis are subject to this methodology.

d. Payment for the professional component of a radiology service performed in an inpatient, outpatient, or office setting will not exceed 40 percent of the allowed amount

payable for the complete procedure in an office setting. Nuclear medicine, radiation oncology, CT scans, and arteriogram are excluded from this limitation.

e. Payment to free standing ambulatory surgical centers does not exceed the maximum allowed by the Medicare Carrier. For procedures not covered by Medicare, the Department establishes a payment level which does not exceed the amount allowed for procedures of similar complexity.

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SUPERSEDES: TN - 90-15

f. Payments for care or service are not in excess of the upper limits allowed by federal regulations.

g. This single State Agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or service, or fee plus costs of materials.

h. The state Agency has access to data identifying maximum charges allowed and such data will be made available to Secretary of HHS upon request.

i. A separate fee schedule for obstetric and pediatric services is maintained in order to demonstrate that the fee-for-service rates will insure these services are available to Medicaid recipients at least to the extent that such services are available to the general population in a geographic area.

j. Payments to licensed midwives are made at the lesser of the actual billed charge or 77% of the amount allowed by the fee schedule for the same service when provided by a physician.

k. Certified nurse anesthetists are reimbursed at the rate per anesthesia unit which the Medicare Carrier was using April 1, 1990. That rate is $12.83 per unit for non-medically directed services and $8.12 per unit for medically directed services.

l. Certified Nurse Practitioners will be reimbursed at 90% of the payment rate paid to physicians as described in Item I of Attachment 4.19-B.

m. Licensed Independent Social Workers (LISWs) and Clinical Nurse Specialists (CNSs) will be reimbursed as described in Item I of Attachment 4.19-B.

n. A separate fee schedule for Personal Care is maintained in order to demonstrate that the fee-for-service rates will insure these services are available to Medicaid recipients.

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SUPERSEDES TN 99-04

II. Payment for prescribed drugs in the New Mexico Title XIX Program shall be based upon the following provisions. The Department will reimburse the lesser of the computed price or the usual and customary charge.

a. Computed Price

The computed price is defined as the allowed cost plus a dispensing fee established by the Department.

The allowed cost will be the lower of the following:

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II. Payment for prescribed drugs.

The Department will reimburse the lesser of the computed price or the usual and customary charge.

a. Computed Price The computed price is defined as the allowed cost plus a dispensing fee established by the department. The allowed cost will be the lower of the following:

1. State Allowed Cost (SAC): (Effective August 11, 1992)

Reimbursement is limited to a lesser-expensive therapeutically equivalent drug per the state Product Selection Act as amended. The "FDA Approved Therapeutically Equivalent Drugs" list must be used to determine which products are therapeutically equivalent. A physician may prohibit drug selection by writing in his own handwriting "brand medically necessary" on the prescription. This constitutes physician certification that substitution is not permitted. With this certification, the SAC limit shall not apply.

In establishing the state Allowed Costs, the New Mexico Medicaid Program will not exceed, in the aggregate, payment levels established by HCFA for multiple source and other drugs, effective October 29, 1987.

2. Estimated Acquisition Cost: (EAC) (Effective April 1, 1989)

EAC is the average wholesale price (AWP) minus 12.5% (Effective July 1, 1997).

b. Usual and Customary Charge

The usual and customary charge is defined as the charge made to a non-Medicaid patient for the same drug item. Usual and customary charges specifically must consider the following:

1. Discounts given to non-Medicaid patients for criteria such as age or being in a nursing home when the Medicaid patient meets the criteria for the discount.

SUPERSEDES TN. 91-06

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2. Discounts for paying cash. If any patient group gets discounts for paying cash. those discounts must be reflected in the usual and customary charge.

3 Medicaid is to be given the advantage of discounts which the general public receives.

c. Prescription Refills - There are limitations on the frequency for which it will reimburse the same pharmacy for dispensing the same drug to the same recipient. The limitation is established individually for each drug. Most drugs are subject to a maximum of 3 times in 90 days with an additional 20 days to account for necessary early refills, etc. Controlled drugs and certain other drugs may require more flexibility due to their specific indications, dosage form, or packaging, and are subject to limitations as may be appropriate.

Refills must be consistent with the dosage schedule prescribed and all existing federal and state law.

The maximum which may be dispensed at one time is a thirty four day supply, except for oral contraceptives which may be dispensed in greater quantities if the proper agent for the patient is established.

d. Dispensing Fee - The dispensing fee for retail pharmacies is $4.00. The fee may not be applicable to physicians, institutions, clinics, and non-profit facilities. The Department establishes the dispensing fee by taking into account the costs of pharmacy operation. The department will periodically survey pharmacy operations including operational data, professional services data, overhead data, and profit data.

e. Reimbursement Limitations

1. Payment will not be made for drugs items for which the manufacturer has not entered into a rebate agreement with the federal government except as specified in the provisions of sections 1902 (a) (54) and 1927 of the Social Security Act.

2. Payment will not be made to physicians for oral medications or medications which can be appropriately self-administered by the recipient. Payment to physicians for drugs will be limited to injectable medications administered by the physician or under his direction in conformance with the New Mexico Medical Review Association injectable medication

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III. For outpatient hospital services provided by approved Title XIX hospitals for Title XIX reimbursement purposes, effective for all accounting periods which begin on or after October 1, 1983, the amount payable by the Medicaid program through its fiscal agent for services provided to Title XIX recipients and covered under the Medicaid program, the manner of payment and the manner of settlement of overpayments and underpayments shall be determined under the methods and procedures provided for determining allowable payment for outpatient hospital services under Title XVIII of the Social Security Act. Effective April 1, 1992, for those services reimbursed under Title XVIII allowable cost methodology, the Medicaid program will reduce the Title XVIII allowable costs by 3 percent. The interim rate of payment shall be 77% of billed charges. These provisions shall be applicable to all hospitals approved for participation as Title XIX hospitals in the Medical Assistance Program.

a. In no case can reimbursement for outpatient hospital services exceed reasonable cost as defined under Medicare Title XVIII. Laboratory services will not exceed maximum levels established by Medicare.

b. Effective for reimbursement for outpatient dates of service beginning March 15, 1978, reimbursement for oral medications dispensed in a hospital outpatient setting or emergency room will be limited to usual charge up to a maximum of $2.00 per visit per Medicaid recipient.

c. Effective April 1, 1992, emergency room services are reimbursed at an interim rate of 77% of billed charges, subject to retroactive adjustment to allowable and reasonable cost minus 3 percent.

d. Emergency room services are subject to review prior to payment to establish if circumstances warranted emergency room service. If it is determined that emergency services were provided in a non-emergency situation, the emergency room charge is denied. The recipient is responsible for payment of the emergency room charge in these cases, and may be billed by the provider directly. The ancillary

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